Qualified Health Insurance Coverage Questionnaire
Individual Shared Responsibility Payment

1. **Did you have Minimum Essential Health Care Coverage for you, your spouse and all of your dependents for each month of 2015? _____YES _____NO**
   a. If "YES" please check: _____Employer (need 1095-C) _____Insurance Co (Non-Marketplace)(need 1095-B)
   _____ Other Government Sponsored (need 1095-B) _____Marketplace (Need Form 1095-A)
   b. If "YES" and no 1095 form provided please provide name of insurance provider in section #3 below and sign in section #5.
   c. If "NO" please complete section #2 below and sign in section #5.
   d. If you think you may be "EXEMPT" please complete section #4 below and sign in section #5.
   e. Was coverage offered thru your employer and you declined?_____ If "YES" why?_____

2. **Check all months that each individual had health insurance coverage**

Name	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Primary Taxpayer												
Secondary Taxpayer												
Dependent 1												
Dependent 2												
Dependent 3												
Dependent 4												

3. **Name of Insurance Provider(s):**_____

4. **Exempt?**
Explain your exemption: _____

5. **Signature:** **Date:**
X _____ _____

PREPARER NOTES:
1. **Advise taxpayer to get 1095-B/1095-C to you when received. If necessary, we will amend tax returns.**
2. **Scan all 1095 forms into "2015 Source Docs"**
3. **Did you check for unaffordability or another exemption?**

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